New England Deaconess Hospital

pulse

185 Pilgrim Road, Boston, Massachusetts

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Education for employees is an important part of AIDS care

The Deaconess admitted its first patient with AIDS nearly six years ago. Since that time, about 350 others — both inpatients and outpatients — have been cared for here. The hospital currently is responsible for establishing the diagnosis in about 25 percent of all the patients with AIDS reported in Massachusetts. (Another 60 percent are shared among Beth Israel, Boston City, Brigham and Women's, Massachusetts General, and other Boston hospitals; the remaining patients are treated at various hospitals throughout the Commonwealth).

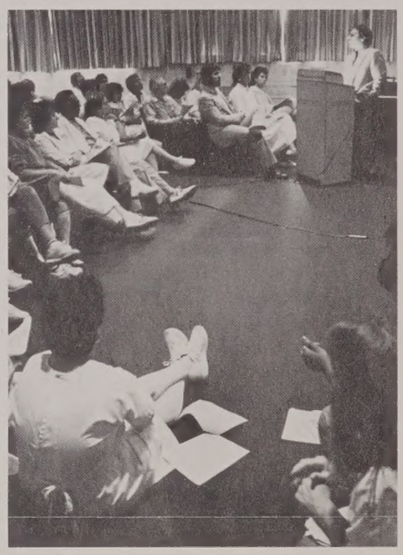
The majority of people with AIDS who come to the Deaconess are seen as outpatients. Last year, the hospital created a multidisciplinary ambulatory care facility based in Harris Hall that now sees more than 450 patients with AIDS or related HIV (human immunodeficiency virus) conditions on a regular schedule. Directed by Davis Allan, M.D., hospital epidemiologist, the clinic provides comprehensive care and support services through a staff of physicians, clinical research nurses, data managers, a nutritionist, and a social worker; the team also relies on the resources of many other hospital departments, such as Nursing and Pastoral Care.

On the inpatient side, the Deaconess now averages 10 to 15 AIDS patients in the hospital on any given day. The majority of these patients are those normally seen as outpatients who have experienced a setback and must be hospitalized.

Because of the number of patients with AIDS at the Deaconess (a number that is likely to increase until effective treatments or vaccines are found), and because of the high level of anxiety that exists among the general public and among health care workers, the hospital recognized a need for AIDS education programs. At the beginning, informational and educational sessions were conducted primarily by Deaconess physicians, nursing staff development instructors, and by the hospital's infection control nurse, who were most familiar with AIDS. The sessions were conducted on an informal basis for departments who felt a need to provide information for their employees as a means to allay their concerns about the disease.

Almost three years ago, this educational effort was broadened through the creation of an AIDS Education Task Force. Its charge was to develop ways to educate employees about AIDS, to combat fear through knowledge, and to initiate additional support systems for departments and individual employees with AIDS-specific problems. The group currently consists of: Suzanne Holloran, R.N., staff development, Nursing; Jim Huddleston, R.P.T., Physical Therapy; Deborah Lichtenberg, R.N., nurse epidemiologist; Marion Longo, R.N., psychiatric clinical specialist, Nursing; Dean Manheimer, Human Resources; Carl O'Donnell, Ph.D., Pulmonary Medicine; and Alison Sneider, Public Relations. A.W. Karchmer, M.D., chairman of the hospital's Infection Control Committee, serves as advisor to the group.

At about the same time the task force was formed, O'Donnell was completing a problem-oriented employee attitude survey about AIDS, in which



Education and information dispel fears and misconceptions.

J. Davis Allan, M.D., hospital epidemiologist, addresses employees at the recent AIDS grand rounds on risk reduction and safe sexual practices.

237 hospital employees were interviewed. "The study confirmed what we had expected," he says. "There were misconceptions and fears about AIDS among some employee groups, but those who had frequent and more social contact with patients were less likely to experience stress as a result of working with AIDS patients."

In an effort to help dispel misconceptions and to alleviate anxiety, the AIDS Education Task Force began to focus on the development of a continuing series of "Employee Grand Rounds," held periodically throughout each year. Designed as an open forum and

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Jeffrey Dover, M.D.

Dover named chief of dermatology

Jeffrey S. Dover, M.D., has been named chief of dermatology, a newly organized section within the Department of Medicine. "I'm very excited about being at the Deaconess," he says. "Our section has become part of Harvard Medical School's dermatology teaching program, and I look forward to expanding the dermatology efforts that have existed here for several years."

Most recently, Dover was a fellow in photomedicine (the use of light to treat diseases) at Harvard Medical School, Massachusetts General Hospital, and Beth Israel Hospital. His work has included using lasers to treat telangiectasia (small, dilated blood vessels that commonly appear on the face or legs), port wine stains, liver spots, and recalcitrant warts; and he plans to continue these activities at the Deaconess.

"We are researching the use of lasers to remove unwanted pigment in the skin," he says, "including looking at the usefulness of different types of laser light. We also are looking for better ways of treating vascular abnormalities of the skin. A further area of development is the use of skin grown in the laboratory to treat leg ulcers."

Dover is a graduate of the University of Ottawa Medical School. He was a medical intern at the Sunnybrook Medical Centre in Toronto, a dermatology resident at the University of Toronto, and overseas senior registrar at St. John's Hospital for Diseases of the Skin in London, England. He currently is an instructor in dermatology at Harvard Medical School.

Making sure the mail goes through

"Every piece of outside mail picked up at the hospital will go out that day."
— Rick Lewis, mail room supervisor

Every morning the U.S. Postal Service delivers 3,000 pieces of mail to the Deaconess — three bags of first-class mail and three bags of magazines, journals, and other materials. An additional 2,400 pieces, both interoffice and outside mail, are sent out daily by departments throughout the hospital. The five employees in the hospital mail room, located in the basement of the Deaconess building, are responsible for sorting these 5,400 pieces (the number can double after a long weekend), delivering mail to the patient floors and hospital departments, and stamping and sending all outgoing mail.

"When the mail bags arrive in the morning, the first thing we do is separate the mail for patients from the hospital business mail," says Rick Lewis, mail room supervisor. "We look up patients on the daily admission and discharge sheets to make sure of their location. Mail for patients who've gone home will be forwarded to them.

"Almost every day we get cards or letters for patients that don't have names on them. They may be addressed to 'Grandma,' or 'Uncle Joe,' or even just to the hospital. We open these letters and try to determine who they're for, but if there is no identification on the inside, we send them back," Lewis says.

The hospital's business mail is sorted into 150 different boxes in the mail room. There are boxes for patient floors, departments, physician's offices at 110 Francis Street, groups at 99 Brookline Avenue, and house officers. Each of the mail room employees is responsible for a section of boxes. Paul Willis, mail clerk, says, "We're able to sort the pieces very fast because we get to know where each department's box is located. We can get all the mail sorted in about an hour and a half."

Deliveries of business mail are made twice a day. The five employees rotate among four regular routes covering the entire hospital (one stays in the mail room) to make deliveries and pick up the departments' outgoing mail. Lewis says, "Probably the question we're asked most frequently is when a piece of mail will go out. Unless our postage machine is broken, every piece of outside mail picked up at the hospital will go out that day. If the machine is broken, we may send the mail down to our satellite mail room at 99 Brookline Avenue to be metered on their machine."

Paul Willis, mail clerk, empties one of the six bags of mail that arrives at the hospital every day.

The 99 Brookline mail room handles all internal mail between the hospital and the financial, materials management, and other offices at that location. Shuttle service runs between the sites several times a day, assuring prompt delivery.

Keith McKenzie, office assistant in charge of the 99 Brookline mail room, says, "In addition to handling regular mail that is sent outside or to the hospital, I'm responsible for mailing all the hospital's bills. Deaconess Professional Practice [the hospital subsidiary incorporating the physician practice groups] sends out about 5,000 bills in

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To assure prompt delivery

Although mail room employees sort and deliver the mail, each hospital employee who sends or receives mail can help avoid delays by following these guidelines:

- Give those sending mail to the hospital complete address information, including the recipient's name and department.
- Interoffice mail should include the recipient's full name, department, and building location.
- Interoffice mail is delivered to all Deaconess locations, Joslin, Overholt, and the Lahey Clinic. But mail for other Longwood Medical Area institutions, including Harvard Medical School, must go through outside mail.
- Interoffice mail should be sent in reusable, manila interoffice envelopes. White letterhead envelopes — especially those with three- or four-line addresses — can appear to be outside mail. They may be sorted as such and sent to the post office, wasting both time and postage.
- When using express delivery services, fill out the accompanying forms completely, including department numbers. Remember that such services are very expensive and should be used only when overnight delivery is essential.
- The mail room does not stock a variety of packaging materials, so those sending out large, unusual items should try to provide their own boxes.

For more information about the hospital's mail service, call the mail room at 2-8262.

Pathology employees ride their bikes to fight MS

Four ambitious members of the Pathology Department rode in "The Great Mass Getaway" for multiple sclerosis. The four riders — Dorrie Napoleone, laboratory computer manager; Allan Paduano, hematology technologist; Clinton Read, lab computer operator; and David Read, phlebotomy supervisor — rode their bicycles 155 miles through Massachusetts, New Hampshire, and Maine during the weekend of June 20 and 21 and raised more than $1,600 for the Multiple Sclerosis Society.

"We decided to do this because several of us know people with MS," says Napoleone. "We're also in the age group that is susceptible to contracting the disease. It was a great weekend. We met nice people and raised money for a good cause."

Gathering before their 155-mile bike ride against multiple sclerosis are Pathology employees (from left) Dorrie Napoleone, Clinton Read, Allan Paduano, and David Read.

AIDS education *(continued from page 1)*

presented on hospital time, each session is divided into two parts: a factual presentation (usually containing an update on the latest clinical information about AIDS); and a question-and-answer period, during which employees are encouraged to ask questions or raise concerns about their involvement with AIDS. Sessions are videotaped and are available for viewing by departments or individuals who are unable to attend.

"Because AIDS is such an emotionally charged issue — as well as a genuine clinical care fact of life here — we felt it especially important to give employees regular opportunities to hear about new developments and also to have a forum for voicing their concerns," says Marion Longo. To date, seven AIDS grand rounds have been held; the next is planned for the week of October 4, which has been designated as AIDS Awareness Week in Massachusetts (see the September *Minipulse* for details). Results of evaluations completed by participants at the meetings are unanimously in favor of their continuation.

In addition to the grand rounds, many other educational efforts have been organized by members of the task force and Deaconess staff, both inside the hospital and for outside groups. For example: more than 100 education sessions have been presented for departments and areas throughout the hospital; the Department of Medicine has sponsored two regional conferences attended by overflow crowds; representatives of Medicine, Nursing, Pastoral Care, Social Service, and many others have given scores of lectures and workshops for schools and other groups ranging from the New England Renal Conference to the New England Conservatory of Music.

The Nursing Department has been deeply involved in continuing education for Deaconess nursing staff and for outside groups as well. Members of the staff development section have conducted many education sessions for various areas; the staff designs and conducts programs for the nursing staffs of other Longwood Medical Area institutions; and members of the department have run special seminars for outside groups, such as area dentists and dental hygienists. "We are developing a videotape series," says Suzanne Holloran, "so that eventually nurses may sign out educational AIDS tapes and receive continuing education units for at-home study. We realize that many nurses are unable to leave the floors at the times of the grand rounds, teleconferences, and other offerings. So the tape series will be another way to help get the word out."

The hospital's continued efforts to "get the word out" seem to be working. A year after the initial employee survey, O'Donnell and colleagues conducted a follow-up study that included responses from more than 200 employees. As in the first survey, information was collected on contact with AIDS patients, knowledge of modes of transmission, and attendance at educational programs. "We found that between 1985 and 1986 staff showed significant improvements in knowledge about AIDS transmission and reductions in the perceived stresses and risks of providing AIDS care," says O'Donnell. "The improvements were seen despite a twofold increase in AIDS admissions. We found that these positive changes were not as likely to occur among staff who didn't attend educational programs."

"We found . . . significant improvements in knowledge about AIDS transmission and reductions in perceived stresses."
— Carl O'Donnell, Ph.D.

Employees appreciate "Grand Rounds" meetings

"The open attitude is excellent. It was good to have someone from the AIDS Action Committee for the first time."
— Volunteer Services

"I appreciate the hospital's keeping employees informed to clear up misconceptions and decrease fear."
— Nursing

"I was pleased that this was presented in a 'non-panic' setting. Thank you!"
— Radiation Therapy

"I've heard most of what was said before. However, it is good to hear again."
— Microbiology

New laboratory tests autonomic nerve functions

One of only a few laboratories in the country to measure the functions of the autonomic nervous system has been established at the Deaconess. The lab, located in the Palmer 1 neurophysiology area, is the only one of its kind in New England.

The autonomic nervous system controls such "automatic" aspects of bodily function as heart rate, blood pressure, breathing, sweating, and digestion. Problems with the autonomic system can be caused by a variety of illnesses — including diabetes, alcoholism, Parkinson's disease, AIDS, and several neurologic and psychiatric disorders — or they may be side effects of certain medications. Some symptoms include lightheadedness or fainting upon standing up (a result of low or unstable blood pressure), visual blurring, gastrointestinal problems, increased or decreased sweating, bladder problems, and impotence.

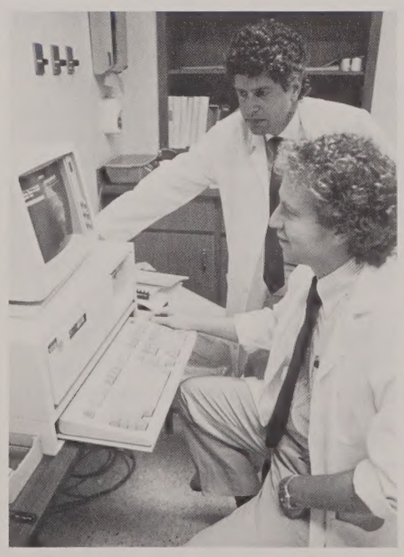
Roy Freeman, M.D., neurologist, is the director of the new lab, and Lawrence Friedman, M.D., general medicine fellow, is assistant director. Freeman says, "We provide a battery of tests to evaluate the presence or absence of autonomic dysfunction. These tests can quantitate heart rate, cardiac reflexes, skin blood flow, sweating, and pupil reactions. Patients with orthostatic hypotension — those whose blood pressure drops when they stand up — are a particular interest of our group.

"We also are looking at the biochemical aspects of autonomic dysfunction — measuring levels of neurotransmitters [chemicals important in transmitting nervous system signals] and hormones like adrenaline. We offer a consulting service to assist with the diagnosis and treatment of patients with symptoms of autonomic dysfunction, and will be testing new investigational drugs that may treat these problems," Freeman says.

Tests available in the lab include electrocardiograms (measurements of the heart's electrical activity), non-invasive blood pressure monitoring, and laser Doppler measurements of skin blood flow. All equipment is connected to a sophisticated computer system that can analyze test results and their relation to the autonomic system almost instantaneously.

Funding for the lab was provided through the William A. Arnold Pain Treatment and Research Center, directed by Melvin Krant, M.D., internal medicine. Krant is a specialist in pain treatment with a particular interest in reflex sympathetic dystrophy, an autonomic disorder.

For more information about the autonomic function lab, call the neurology section at 732-8837.



Lawrence Friedman, M.D., (foreground) and Roy Freeman, M.D., worked with Harvard postdoctoral student Jason Harry to devise the computer program — the most sophisticated of its kind — which analyzes tests performed in the autonomic function lab.

Flexible benefits program announced for Deaconess employees

Starting January 1, 1988, all eligible Deaconess employees will participate in a new flexible benefits program. The new program was outlined briefly in the last issue of *Pulse,* and is presented in more detail here.

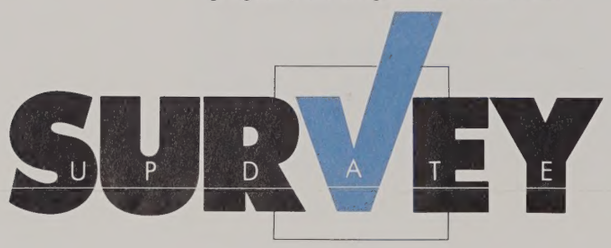
Flexible benefits is a program designed to give employees:

- control over benefits through choice, and the ability to change choices as needs change;
- tax-effectiveness in paying for coverage and in paying certain health care and dependent care expenses;
- cash in exchange for benefits.

At the same time, the program is designed to help the hospital:

- be more responsive to employees' changing needs;
- better manage the dollars spent on benefits;
- slow the rise in health care costs (see accompanying article on costs).

The concept behind flexible benefits is simple. Currently, the Deaconess contributes toward a broad range of benefit coverages, including medical, dental, and life insurance. With the flexible program, the hospital still contributes toward the cost of coverage — maintaining the same level of support. But now, employees will be able to decide how that money should be spent.



The hospital has priced all coverage levels of every benefit category according to their actual cost to the hospital. Within each benefit category, the hospital has assigned a specific dollar amount of support it can provide. If an employee feels that a higher level of insurance protection is necessary, the employee is asked to pay the additional cost for that more expensive option. If, on the other hand, an employee only needs a lower level of insurance protection, or none at all, the hospital will share the savings in the insurance premium by adding "flexible dollars" to the employee's pay each week. These dollars might then help offset the cost of other benefits, or be used for cash.

What is flexible; what is not

The following benefit areas are included in the new program:

- medical insurance
- dental insurance
- employee life insurance
- accident insurance
- dependent life insurance
- reimbursement accounts.

Each of these "flexible" components of the new program is described below.

For legal and tax reasons, some benefit areas are not flexible, and are not included in the new program (though they will continue just as they are now):

- vacation
- sick leave
- long-term disability
- tuition assistance
- savings and investment (TSA I and TSA II)
- pension.

Medical

As part of the flexible program, there will be two new medical options to consider as well as an improvement in the coverage currently available.

One new option is "no coverage." Employees who have medical coverage available elsewhere (through a spouse, in most cases) need not have medical coverage through the Deaconess at all. But it will be necessary to sign a statement indicating that coverage exists through another policy; this will reassure the hospital that no employee will be left without medical coverage should it be needed.

The other new option is Blue Cross/Blue Shield Comprehensive. This covers the same types of expenses as do other Blue Cross/Blue Shield options — hospitalization, surgery, doctors' fees, and prescription drugs, for example. The difference is that the Comprehensive option provides a lower level of "first dollar" coverage. The insurance initially will pay less and the employee will pay more for the first claims of a year, until a higher deductible and a co-insurance are met. But the coverage is also less expensive. The concept is much like that of car insurance: those

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Rise in health care and other costs affects all employers

One of the many factors that has contributed to escalating health care costs — at the Deaconess and elsewhere — is the dramatic rise in costs for providing benefits coverage, particularly medical benefits. Last year, the Deaconess spent $2.7 million to provide medical benefits; this amount is expected to total at least $3.1 million by the end of 1987 (an increase of 15 percent). Future increases are likely to be less dramatic, though still in the range of 8 to 10 percent per year.

Since 1984, the hospital has absorbed these increased benefit costs. For many reasons (the government-mandated cap on the revenue the hospital can receive; the ever-increasing operating costs of the hospital; and others), the hospital can no longer absorb all the cost increases. So, beginning in October 1987, employees will be asked to share some of these increased coverage costs.

The increases in the employee-paid portion of the health coverage benefit are necessary. However, the flexible benefits program that starts January 1, 1988 has advantages that will cushion the total cost impact for many employees. The reason that employee costs will not be as high as they seem is that under the flexible benefits program, these costs will be paid on a before-tax basis. In other words, an employee's share of coverage costs will be paid with dollars that are not taxable. As a result, an employee's federal, state, and Social Security taxes will be lower.

Mail room *(continued from page 2)*

the middle of the month; that takes about four days to get into the mail. And there are about 3,000 bills sent to hospital inpatients and outpatients every month."

In addition to the 99 Brookline service, the mail room also delivers interoffice mail to Joslin Diabetes Center, the Overholt Clinic, and the Lahey Clinic. Another service is overnight letter or package delivery through either Federal Express or the Postal Service's Express Mail program.

Sandy Sullivan, acting department manager for the mail room, says, "I think the mail room staff does a great job. During the past few years, the hospital has added new departments, labs, and the 99 Brookline offices. The mail room staff has not increased, but they are providing the same level of service. With the cooperation of all hospital employees, they can continue to improve their service to all hospital departments."

Flexible benefits

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who accept a higher deductible make much lower premium payments.

The currently available Blue Cross Options — Major Medical and Master Medical — will continue to be available. (Major Medical requires that patients pay a deductible and 10 percent of covered charges. Master Medical provides full payment for covered hospital services.) The improvement mentioned above relates to Major Medical: while providing the same coverage, the improvement reduces an employee's maximum out-of-pocket expenses from $700 to $350. This reduction lowers significantly an employee's annual out-of-pocket "risk."

Dental

As under the current program, an employee may elect to have no dental coverage at all. But for those who wish to have dental insurance, the new program offers improvements — complete coverage and no deductible. In the past, the plan paid 90 percent of eligible diagnostic and preventive care expenses, and the employee paid 10 percent. With the improved coverage, however, the plan will pay 100 percent of diagnostic and preventive care expenses.

Life insurance

With the flexible benefits program, the current life insurance coverage will continue to be available for employees and their dependents. There are two additional features as well: a new type of employee accident insurance, and a higher level of dependent insurance coverage.

The new employee accident insurance is optional, chosen and paid for with employee before-tax dollars only if an employee wishes to purchase it. This new accident insurance pays a benefit to a designated beneficiary should an employee die in an accident. It also pays a partial benefit to an employee who suffers a severe physical loss as a result of a personal injury or accident.

The new, higher level of dependent insurance provides life insurance coverage over and above what is available currently. This higher level of coverage pays a $10,000 benefit for the death of a spouse, and a $5,000 benefit for the death of any dependent children.

Reimbursement accounts

This is an entirely new benefit area for the Deaconess, and is possible only because of the new Deaconess flexible benefits program. There are two kinds of reimbursement accounts: health care and dependent care.

Using these accounts is optional. An employee deposits his or her own money in the accounts. The advantage is that the money set aside is deducted from an employee's pay before taxes are withheld. This reduces an employee's federal, state, and local tax obligation. So, in effect, these reimbursement account expenses are paid for with tax-free dollars.

The health care account pays for things that medical and dental coverage do not pay for, such as: deductibles, if any; vision and hearing care expenses; orthodontia; regular physical exams; well baby care; chiropractic care; and cosmetic surgery.

The dependent care account pays for dependent care services used that enable an employee (and spouse, if married) to go to work. A dependent may be a dependent child or a disabled dependent who lives in the employee's home.

Using these reimbursement accounts takes careful planning. Employees who wish to use the accounts will decide at the time of enrollment how much to set aside in them. The accounts then may be used throughout the year for reimbursement of eligible expenses. *It is important to recognize that, under the current tax laws, any money left over in these accounts at the end of a calendar year is forfeited.* So the only money that should be put into a reimbursement account is money that is certain to be used by the end of the year.

Flexible benefits give employees greater choice and help the hospital manage rising costs.

Answering employees' questions about the new flexible benefits program

Mark Grubbs, manager of compensation and benefits in the Human Resources Department, has anticipated some of the questions that employees might ask about flexible benefits, and has provided some simple answers. Other questions about flexible benefits will be answered through information sessions for employees to be held later in the fall.

Q: Who is eligible to participate?
A: For now, the rules will not change: all full- and part-time employees who work at least 30 hours a week may participate. New employees will be eligible to participate on the first of the month following 30 days of employment.

Q: Why has the hospital decided to start this program now?
A: First, over the past several years, we've seen an increase in the number of working couples and single parents. With the workforce changing this way, and with their needs changing as well, we felt that the Deaconess should have a benefits program that recognizes this diversity and is more responsive and more capable of meeting employees' needs.

Second, the Deaconess, like most businesses in the U.S., has seen a dramatic rise in health care costs [see accompanying article on costs]. We've struggled for some time to come up with a program that helps the hospital to manage these costs and to continue to provide quality benefits to our employees. Flexible benefits does this. It allows us to continue an already excellent benefits program that is both tax-effective and adaptable. At the same time, it helps the hospital manage rising costs.

Q: But won't costs continue to rise regardless of what kind of benefits program the hospital has?
A: Yes, but flexible benefits can help us slow that increase, because employees who "shop carefully" for their benefits help the hospital to spend only what it needs to spend. Under the current program, we are paying for all employees to have coverage — and relatively high levels of coverage at that — whether they need it or not. Take medical coverage, for example. More than half of Deaconess employees have Blue Cross Master Medical or participate in an HMO. But these are high-option insurers that cost us a lot to provide coverage. Some employees don't need this much coverage, and could get by with less or even none at all. A flexible program allows for this. For those employees who aren't often sick, there's a lower level of coverage available. And for employees who have medical coverage outside of the Deaconess, there's an option to take no coverage at all. Employees who can take less will share in the cost savings.

Q: So the hospital will spend less on benefits than in the past?
A: Not really. In fact, we'll spend as much for the flexible program as we would have spent for the current benefits program, and perhaps even more in the first year, considering start-up costs. The flexible program is not intended to help us cut current costs; it's intended to help us manage them for the future.

Q: What about choice? Will employees like having a choice about their benefits?
A: We think so. To find out, we conducted focus group sessions in June with a cross-section of employees. They told us they wanted to be able to choose their own benefits. Most also said they felt comfortable in taking on that responsibility.

Q: When will employees have to make their enrollment decisions?
A: In November, though we will distribute a lot of information before then to help with the decision-making process. Later this month, employees will receive a special brochure that explains the highlights of the new program.

Major effort aimed at controlling patient length of stay

All hospitals today are caught up in a balancing act: balancing their patients' needs for health care services with a need to control costs and assure the institution's financial survival. While the costs of delivering tests, medications, procedures, and personalized care increases, the amount of money hospitals are reimbursed for their services is being reduced.

The Deaconess is no different, and over the past few months the hospital has experienced a serious discrepancy between the costs incurred in caring for its patients and the income received from third-party payors like Blue Cross, Medicare, and insurance companies. One reason for this situation has been an increase in length of stay — the number of days the average patient spends in the hospital.

"The medical and nursing staff members working on the floors have the knowledge to identify problems and develop better working systems."
— Curt Smith, senior vice president, operations

Curt Smith, senior vice president for Operations, says, "Almost half of our patients are covered by Medicare, and under the Medicare DRG (diagnosis related group) system, the hospital is paid on the basis of a patient's illness, not on how long he or she stays in the hospital. During the first half of the 1987 fiscal year, our average length of stay increased from 10.1 days to 10.8 days — more than half a day. That may not seem like much, but when you multiply it by the more than 13,000 patients admitted to the Deaconess every year you get thousands of 'days' of care delivered with no additional reimbursement."

Unnecessary patient days targeted for reduction

To deal with this problem, the hospital has launched a major effort to control length of stay by reducing the number of days patients spend in the hospital unnecessarily.

"One example of the kind of delay we're trying to reduce," says Smith, "occurs in our cardiac catheterization program. When patients are transferred to the Deaconess from community hospitals for a non-elective catheterization, they can wait in the hospital three or four days before the procedure is done. If the cath shows they need to have bypass surgery, there can be another delay of about five days before the operation is performed."

"With the large number of critically ill patients transferred from referring hospitals," says Samuel Shubrooks, M.D., director of the catheterization lab, "we have experienced excessive delays because of both the limited beds in our coronary care and progressive cardiac units and the time available in the lab, which is one of the most active in Boston. We have begun an intensive program involving physician, nursing, and secretarial staffs aimed at coordinating transfers with cath scheduling, in an attempt to reduce delays, consistent with good patient care."

Similar delays can occur near the end of a patient's hospitalization in the absence of proper discharge arrangements — for a transfer to another facility, home health care services, or even a ride home. Often these problems are outside of the hospital's control.

"It's much more complicated than people think," says George Starkey, M.D., thoracic surgeon and chair of the quality assurance committee. "We have had patients apply to up to 50 nursing homes and not be accepted. They are waiting in the hospital, where they really don't need to be, long after their Medicare runs out. There are problems for patients who should be able to go home but their families cannot care for them or there are not sufficient home nursing services available in their communities."

Efforts in vascular surgery

Vascular surgery is another area that has been targeted for length of stay reduction, and the Farr 9 vascular cluster unit is the center of efforts to reduce delays in vascular patient care.

Linda Denekamp, R.N., Farr 9B head nurse, says, "A lot of our patients are now admitted the day of their procedure instead of coming the night before. The nursing staff assesses each patient's discharge needs, and they get the social workers and physical therapists involved in discharge planning as soon as possible. The staff recognizes the problem, and they are trying to balance the hospital's very real need to cut back patient days with maintaining patient satisfaction."

Janet Connolly, R.N., Farr 9A head nurse, says, "Everyone on the floor works very well together with the surgeons, physical therapists, social workers, and utilization review staff. We're finding that simplifying the lines of communication among these groups is a big part of the project."

"We've made a lot of progress in cutting costs and getting patients home sooner," says Gary Gibbons, M.D., chief of vascular surgery, "But trying to care for patients within the boundaries imposed by Medicare is very frustrating, especially for our patients with diabetes.

"For example, 60 to 70 percent of diabetic patients having vascular surgery need more than one operation, perhaps an arterial bypass and a toe amputation," he says. "But Medicare pays for only one procedure. The DRGs also don't take into account the fact that diabetics have a much greater risk of complications. So one of the other things we're doing is letting groups like the American Diabetes Association know about this problem. They can lobby Congress to make the reimbursement for diabetic care more realistic."

New programs emphasize preadmission testing

Several programs to reduce length of stay have been designed and administered by Jane Erskine, R.N., preadmission coordinator. She will expand these activities as part of the current effort.

Many programs involve reducing the amount of time patients spend in the hospital before a procedure. In the post-operative admission (POA) program, patients scheduled for certain elective surgical procedures come to the hospital as outpatients the week before they are admitted. During this visit they have lab tests, a physical exam and medical history, preoperative teaching and assessment, and an interview with an anesthetist. The day of their surgery they come to the hospital in the morning, have their surgery, and are officially admitted when they are taken to the nursing floor after the operation.

Erskine says, "More and more surgery now is done through the POA program, and third-party payors are more selective of the types of surgery for which they will cover a preoperative night in the hospital. Anyone who doesn't need special preparation the evening before surgery is a candidate for POA."

Similar programs of post-procedure admission have been implemented to eliminate the night spent in the hospital before an elective cardiac catheterization, angioplasty, or angiogram. Patients have necessary tests done as outpatients the day before, and may return home or stay in the hospital's "Guest Quarters" accommodations overnight before returning for their procedure in the morning.

Streamlined systems may personalize patient care

Erskine also will try to reduce scheduling delays by encouraging physicians to place orders for diagnostic tests and consultations before their patients are admitted. Similarly she and other members of the Admitting office will gather necessary information about patients as early as possible. A new admission order form will request more details about patients and their needs, to help plan both hospital care and discharge services. Improved communications with patient families and with community hospitals will help assure that patients are cared for in the setting most appropriate to their needs.

"We will work individually with the physicians to tailor each admission to the particular patient's needs. In many ways, the care will be more personalized," Erskine says.

Although initial results of the program have been excellent — average length of stay has decreased significantly in the first three months — controlling unnecessary patient days must be a long-term effort. Smith says, "This kind of 'clinical engineering' — changing hospital systems, changing the way physicians admit patients or order procedures — can be difficult and

(continued on page 7)

Changes made to materials storage, handling systems

The hospital's materials center has moved to rented warehouse space in Roslindale. The off-campus location affords considerably more space for storage of supplies and equipment. Supplies will be delivered several times a day to the new materials service center located in the space previously occupied by the Laundry. (The hospital's laundry service has been transferred to outside vendors.)

Dick Delaporta, director of Materials Management, says, "The new warehouse is only four miles from the hospital, and we are working very hard to make sure employees will not notice any slowdown in supply distribution because of the new system. The hospital's truck makes a major delivery once a day, and we'll be getting a van to run back and forth with smaller shipments throughout the day. We also keep limited amounts of essential supplies on hand in the service center for emergencies."

Along with the warehouse, several changes have been made to the materials handling and distribution systems. Exchange carts, which are stocked with standard supplies for a department or unit, will be used in more areas. The carts are replaced and restocked on a regular schedule, and units are charged only for the supplies they actually use. Distribution schedules have been changed so that more deliveries within the hospital are made in the evening, taking some load off the elevators.

Materials Management also is working with Zee Gorman, Administration, to analyze the hospital's storage needs and systems. Departments will be asked to review the materials they have in storage and determine what should be retained and how accessible it must be.

Delaporta says, "We use several warehouses for long-term storage; those that are further from the hospital are less expensive. We want to come up with a strategy for storing all our materials in the most appropriate, economic location."

Rick Tranfaglia, Materials, Management, stacks supply cartons in one of four storage rooms in the new materials center.

Length of stay *(continued from page 6)*

frustrating. Efforts to reduce a particular patient's length of stay may not work out, and that's all right. We can't cut out all unnecessary days, but every reduction we do make is a success.

"There is a lot of enthusiasm among the nursing staff, the residents, and the clinical department chairmen for this program. We want to encourage everyone to think about length of stay and pass on any ideas they may have to their department heads," says Smith. "Administration must create an atmosphere to encourage change; it's the medical and nursing staff members working on the floors who have the knowledge to identify problems and develop better working systems."

Guest relations committee reorganized

Last summer, the Deaconess adopted and distributed a formal statement of its commitment to the philosophy of guest relations *(Minipulse,* August 1986). Reaffirming a traditional Deaconess value — "the patient always comes first" — the hospital's guest relations commitment emphasizes that courtesy, compassion, and friendliness are a part of everyone's job at the Deaconess.

While everyone shares in the responsibility for caring for patients (in the widest sense of the word), there is a need for a structure to help focus guest relations activities throughout the hospital. This summer, a multidisciplinary Guest Relations Committee was formed, chaired by Paul Somoza, senior vice president for Marketing and Planning. The new committee incorporates many members of the old Patient Satisfaction Committee, and includes a wide range of employees and staff from departments that have regular contact with patients, families, and visitors.

"The committee recognizes that there are several roles inherent in an effective guest relations program," says Somoza. "Our charge is to attempt to define those roles and to create an environment at the Deaconess where guest relations is 'second nature' to all of us." These roles include: instilling in new employees and reaffirming in current employees traditional Deaconess values; establishing standards of behavior for all staff and employees; advocating the enhancement of a healthy guest relations environment at the Deaconess; and measuring, monitoring, and reporting program results.

To help get the program off the ground, several subcommittees have been formed: patient satisfaction, chaired by Hugh Wheeler, Radiology; orientation and education, chaired by Dean Manheimer, Human Resources; standards, chaired by Somoza; programs, chaired by Joanne Wade, Dietetics; good ideas, chaired by Barbara Stank, Building Services (see below); and communication, chaired by Alison Sneider, Public Relations.

Other committee members are: Wendy Beals, Operations; William Flatley, Admitting; Richard Floyd, Operations; Eleanor Lowry, Patient and Family Relations; August Niewenhous, Safety and Security; David O'Brien, Fiscal Services; Dorothy Ross, Marketing; Guy Steele, Pastoral Care; Mary Jo St. Peter, R.N., Nursing; Ronald Silvestri, M.D., Medicine; Joyce Tower, Operations; and Phyllis Wasserman, Volunteer Services.

Wanted: Good ideas for good guest relations

It is often true that people who are personally involved in something are most likely to have good ideas for improvement. Making a good thing better is the basis of creativity; the product is "a better mousetrap" — a better way of doing things.

"That is what our subcommittee is looking for," says Barbara Stank, chair of the good ideas subcommittee of the Guest Relations Committee. "We know from past experience that Deaconess people have terrific suggestions for ways to improve the Deaconess. We hope that employees will devote some of their creative energies to thinking about ways to enhance guest relations — anything from revising our current systems to providing additional services for guests

"We will respond to all suggestions within a week of receiving them," she says.

Good ideas suggestion

Name:_____ Date: _____

Department: _____ Location: _____

Here is my good idea for improving the hospital's guest relations environment:

_____

_____

_____

_____

_____

_____

Please clip and mail to Barbara Stank, Building Services, Deaconess G.

news in brief

Andrea Bull-McDonough, M.S., R.D., Dietetics, published two articles in *Topics in Clinical Nutrition:* one on the health implications of obesity and a second, coauthored by **Beth Cronin, M.S., R.D.,** Dietetics, on nutrition management of morbid obesity in conjunction with surgery. Bull-McDonough also spoke on patient compliance and weight loss with a gastric bubble program at the American Society for Bariatric Surgery.

Orrin Davis, M.D., otolaryngologist, has joined the Department of Surgery. He recently completed a fellowship in head and neck surgery in Indianapolis and was a resident at Northwestern University. He has particular experience in the problems of vocal restoration, mandibular reconstruction, and facial cosmetic surgery.

John R. Delfs, M.D., neurologist and associate director of the William P. Arnold Pain Treatment and Research Center, has been appointed to the ethics and humanities subcommittee of the American Academy of Neurology. He also was named medical coordinator of the Alzheimer's disease and related disorders program at Sherrill House.

Anna Maria DiCenso, R.D., Dietetics, spoke on the benefits of dietary fiber for diabetic patients to the Woonsocket (Rhode Island) Diabetes Club.

Steven R. Goldring, M.D., chief of rheumatology, spoke on monokine modulation of the immune response to the American Rheumatism Association and on biologic responses to implant biomaterials used for total joint replacement at the Gordon Research Conference.

Howard M. Goodman, M.D., gynecology/gynecologic oncology, has joined the Department of Surgery. He had been associated with Mount Sinai Hospital and School of Medicine in New York and completed his residency and a fellowship in gynecologic oncology at Brigham and Women's Hospital.

Herbert Gramm, M.D., radiologist, was area medical chair for the American Cancer Society's mammography screening project.

Hubert Johnson, M.D., vascular surgery fellow, was named second runner-up for his presentation on the role of duplex scan in the non-invasive evaluation of deep venous thrombosis at a symposium on current issues in venous disease sponsored by Jobst.

Leo P. Krall, M.D., internal medicine/diabetes, wrote an article on the treatment and education of diabetic patients in developing nations, published in *Medicographia,* a journal widely circulated in Europe and Asia.

Stephen J. Lahey, M.D., cardiovascular surgeon, has joined the Department of Surgery. He has completed fellowships at the New York Hospital/Cornell Medical Center and Memorial Sloan Kettering Cancer Center and will concentrate on treatment of lung cancer.

Elaine Launer, marketing associate, has been accepted as a nominee in the American College of Healthcare Executives.

William Lockard, M.D., administrative pathologist, was section editor for advanced exercises for *Study Guide to Clinical Chemistry,* published by Hanley and Belfus, Inc.

Frank LoGerfo, M.D., general/vascular surgeon, has joined the Department of Surgery. Previously a professor of surgery at Boston University Medical Center, he has been appointed director of a new vascular surgery research program.

Eleanor Lowry, coordinator of patient and family relations, was elected president of the Mass. Society of Patient Representatives.

Keith Marton, M.D., chief of general internal medicine, spoke on the assessment and modification of the efficacy of diagnostic imaging at the annual meeting of the International Society of Technology Assessment.

Kenneth Marshall, M.D., plastic surgeon, was re-elected secretary of the Mass. Plastic Surgery Society.

William V. McDermott, M.D., retired chairman of the Department of Surgery, published a comparative study of cancer in East Africa and North America in *Surgical Rounds.* McDermott also was named alumni relations director at Harvard Medical School.

Daniel Miller, M.D., chief of otolaryngology, spoke on multidisciplinary treatment of head and neck cancer at a Harvard Medical School continuing education program on otolaryngology held in Paris.

Charles M. Norris Jr., M.D., otolaryngologist, has been elected to the American Society for Head and Neck Surgery.

Frank Pomposelli, M.D., general/vascular surgeon, has joined the Department of Surgery. He is a graduate of the Deaconess-Harvard Surgical Service residency program and recently completed a fellowship at New York University Medical Center.

Arturo Rolla, M.D., endocrinology/metabolism, spoke on thyroid carcinoma, glycosilation of proteins in diabetes, and thyroid function tests as visiting professor at the Northeastern University Medical School in Argentina. He also recently spoke on rheumatological manifestations of diabetes at Spaulding Rehabilitation Hospital, on treatment of anorexia nervosa at Boston University Medical Center, and on the hormonal and metabolic response to surgery and anesthesia at New England Medical Center.

Albert Sheffer, M.D., chief of allergy, spoke on the fatality-prone asthma sufferer to the asthma mortality workshop at the annual meeting of the American Thoracic Society. Sheffer also established the Asthma Mortality Task Force of the American Academy of Allergy and Immunology, in collaboration with the American Thoracic Society; the Food and Drug Administration; the National Institute of Allergy and Infectious Diseases; the National Heart, Lung, and Blood Institute; and the World Health Organization.

Michael Stone, M.D., surgeon/surgical oncologist, has joined the Department of Surgery. A graduate of the Deaconess-Harvard Surgical Service residency program, he completed a fellowship at Memorial Sloan Kettering Cancer Center. In addition to oncology, his practice will include liver transplantation.

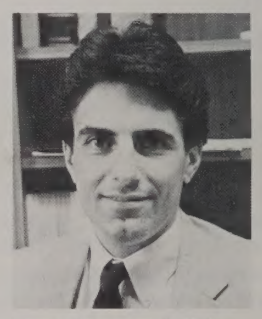
Elizabeth Woodworth, medical staff coordinator, has been named a certified medical staff coordinator by the National Association of Medical Staff Services.

Gloria Wu, M.D., ophthalmologist, has joined the Department of Medicine. She is associated with Joslin Diabetes Center.

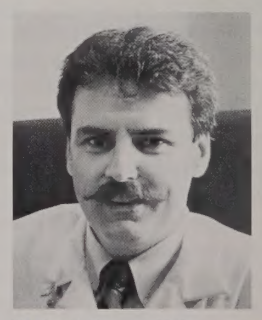
Orrin Davis, M.D.

Howard Goodman, M.D.

Frank LoGerfo, M.D.

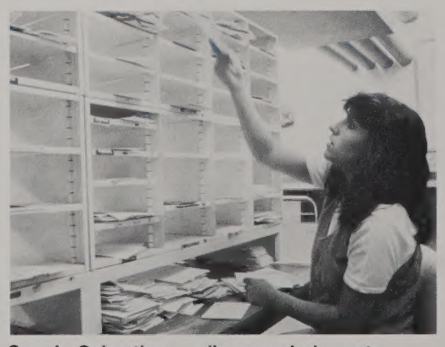


Frank Pomposelli, M.D.



Michael Stone, M.D.

Making sure the mail goes through (see page 2)



Connie Sebastian, mail room clerk, sorts some of the 5,400 pieces that are handled by the mail room every day.

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Editor: Susan R. McGreevey
Contributor: Terry O'Sullivan